

Patient Joint Counts in Rheumatoid Arthritis — “Cents-ible or Cents-less?”



Rheumatoid arthritis (RA) is a potentially devastating disease leading to disability and possible premature mortality¹⁻³. Clinical trials remain the gold standard for evaluating effectiveness of interventions, but the nature of chronic diseases requires “real-world” validation⁴. There are challenges to capturing data in clinical practice — a substantial one is that rheumatologists in clinical practice have their own approaches to judging disease activity, with some inconsistencies in how they are applied⁵. Attempts to encourage clinicians to use validated disease assessment tools (the cornerstone of many being the physician-performed joint count)⁶ have largely failed; most visits of patients with RA do not include a formal quantitative joint count⁷.

In this issue of *The Journal*, Levy, *et al*⁸ postulate that if the time burden of collecting the data is shifted from physicians to patients, then more physicians would use these tools in their regular practice, and (implicitly) their patients’ care would be improved. They share their experience with a Computerized Health Assessment Questionnaire (HAQ-ulous) developed specifically to allow patients with RA to record their swollen and tender joints. The program utilizes these data along with laboratory results to calculate the Disease Activity Score-28 (DAS28); current results are compared with previous scores, displayed in a tabular format. The busy clinician is thus able to assess quickly the effectiveness of the patient’s current therapy. The authors suggest that physicians would use such a program if validated.

Poor correlation of physician versus patient assessment of swollen joints has been demonstrated in earlier studies^{9,10}. To address this problem, patients in the current study underwent training to distinguish swollen from enlarged joints prior to their first use of the program, and again on a return visit. This resulted in an improved physician-patient correlation for swollen joint scores. The authors claim that the primary goal of validating the HAQ-ulous as a tool to

assess disease activity in RA was therefore achieved. The authors admit that a potential weakness of the study is the incomplete spectrum of disease; the patients had low numbers of active joints (at the second visit, only one patient had more than 5 swollen joints). Further study is required to demonstrate correlation of the HAQ-ulous across the broad spectrum of disease activity. In addition, although the DAS28 has been validated as a measure of clinical activity^{11,12}, its use in evaluating remission has been questioned¹². Moreover, the exclusion of foot and ankle joints in the real world is problematic; their omission may cause underestimation of disease activity, leading to undertreatment of disease and possibly denial of therapy by insurers.

From this author’s perspective, these criticisms pale in comparison to the main problem with all reports to date: no studies have measured the real time it takes to use these tools. Of course we need validated assessment tools, but all will continue to collect dust on the shelf until the actual time required to use them in an average office or hospital practice is known. Drs. Pincus and Wolfe¹³ report time savings with their use of questionnaires, but don’t offer proof. With respect to the HAQ-ulous, who trains (and if necessary, retrains) the patient? What is the timing of blood tests with respect to the clinic visits and who enters the laboratory data and when? What is the average length of time per patient per visit, both pre- and post-utilization of the program? Do the patients enter their information in the privacy of an examination room or in the public waiting room? If the former, how much longer are patients in the examination rooms? (This is particularly important if clinic space is shared.) If utilizing the HAQ-ulous results in inefficient use of clinic space despite saving physician time, the net result will be lost income and abortion of the program.

Patient adherence to treatment programs is directly linked to their satisfaction with the clinical encounter¹⁴. It is therefore pertinent to inquire in studies of this type how patients perceive the encounter. If visit time is increased,

See Validation of patient-reported joint counts in RA and the role of training, page 1261

but time with the clinician is decreased, patient satisfaction may decline despite any physician-perceived improvement in care. How will patients perceive future interactions if the physician interacts with the computer screen rather than with them?

The HAQ-ulous has promise for improved and efficient patient care. It does need to be validated on a broader spectrum of disease activity, but even if (or when) this is done, real barriers to utilization must be addressed if expectations for its widespread adoption are to be realized. It is not enough to show that patient self-reports are valid. They must not only be seen to save time, but they must be proven to save time. So time will have to be measured. Until then, practice patterns will not change. Convince busy clinicians of time savings with the HAQ-ulous, and they will see the “cents” of it.

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